Maricopa County Employee Benefits

$100 Hospital Copayment Request for Reimbursement

Group # POS1

Effective January 1, 2003, all employees (Active, COBRA and Retirees) enrolled in the CIGNA Prime Option Point of Service (POS) Plan have a $100 hospital copayment for each inpatient hospital admissions. However, Maricopa County will reimburse employees the entire amount of $100 per admission once the employee completes a request for reimbursement form and submits the form and information that confirms the hospital admission to the Employee Benefits Division in a timely manner.

The copayment applies to an admission to a hospital for an inpatient stay of 24 hours or more. The admission must occur before Employee Benefits will process the reimbursement. However, it is not necessary for employees or their dependents to pay the hospital before Employee Benefits will process the copayment reimbursement. All requests for reimbursements must be made no later than six months following the date of the admission. Requests received after this date will be denied and the employee will be responsible for paying the $100 copayment.

Administration and Reimbursement Process

Maricopa County Benefits Division will accept either a receipt, invoice, or bill from the admitting hospital for a covered employee or dependent as documentation of the admission. The employee must complete the request for reimbursement form and attach supporting documentation. The documentation must include:

- ❑ Name of individual admitted
- ❑ Employee identification number (SSN or Employee ID#)
- ❑ Home address of employee
- ❑ Name of Hospital
- ❑ Date of Admission

Mail or fax the form and documentation to the Employee Benefits Division:

Maricopa County Employee Benefits Division
301 West Jefferson, Suite 201
Phoenix, AZ 85003

Or

Fax: 602-506-2354

Employee Benefits will mail the reimbursement check via U.S. Postal Service to the employee's address as shown in the payroll system unless the employee indicates on the request for reimbursement form that he/she will pick up the check in the Employee's Benefit Office.

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Employee Information

(Please Print)

Status	Social Security # (voluntary)	Last Name	First Name
❑ Active ❑ COBRA ❑ Retiree	Employee Identification #:		

Mailing Address	City	State	Zip Code

Home Phone #	Work Phone #	Email Address (voluntary)

Claim Information

The employee must submit a completed request for reimbursement form & attach a receipt, invoice, or bill showing the covered person was admitted to a hospital as an inpatient. The claim must be filed within 6 months from the date of service. See reverse side of form for information on documentation requirements.

Health Plan Identification # (as shown on your medical ID card)	Name of Person who was admitted		**Relationship to employee**
	Date admitted	Date released	❑ Self ❑ Spouse ❑ Child

Name of Hospital	Hospital Address	Hospital Admissions Phone Number #

Mail or fax completed form and documentation to:

Maricopa County Employee Benefits
301 West Jefferson, Suite 201
Phoenix, AZ 85003
Fax: 602-506-2354

Consent to Release Information

I authorize (Hospital Name) _____to release admitting information for the purpose of validating this claim for reimbursement.

Employee's Signature: Date:

Payment Authorization

I authorize payment directly to:	**I request delivery of my check:**
☐ Employee's Address (as shown in payroll system) ☐ Hospital Name & Address (as shown above)	☐ Mail via U.S. Postal Service ☐ Hold check for pick-up in Employee Benefits Office

Certification

Any Person who knowingly and with intent to defraud files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime.

I certify that the information contained on this form is true and correct.

Employee's Signature: Date: